

The advantages of this method consists in the following points: The poster. tibial artery remains intact, saved for the stump (see Figs. 3 and 4); the tendo Achillis and bursa mucosa retro-calcanea remain uninjured, and the surfaces of the bones sawn off will correspond to each other (see Fig. 4), thus favoring the process of ossification.

In 1877, during the Turko-Russian war, when there were many soldiers with frozen feet, Prof. Tauber tried his method with gratifying results. He believes that in his method preserving the poster. tibial artery there is far less danger from the necrosis of flaps than in the other methods. As to the technique of the operation Tauber's method seems to be less complicated than those of the surgeons mentioned above. However, experience is needed to prove all that Prof. T. claims for his method.—*Vratch* (St. Petersburg). No. 5. Jan. 30, 1886.

P. J. POPOFF (Brooklyn).

#### VASCULAR SYSTEM.

**I. Laparotomy in the Treatment of Spontaneous Gluteal and Sciatic Aneurism with a Report of Three Cases, in One of which Both Internal Iliac Arteries were Tied at the Same Time for Double Gluteal Aneurism of Simultaneous Development.** By F. S. DENNIS, M.D., (New York). (1) Laparotomy in no way increases the dangers of the operation of ligature of the internal iliac artery. (2) Laparotomy prevents a series of accidents which have occurred during the performance of the operation of ligature of this artery by the older methods. Among these accidents may be mentioned the division of the circumflex and epigastric arteries, wounding the vas deferens, including the ureter in the ligature, puncture of the iliac or circumflex veins, tying the genital branch of the genito-crural nerve, stripping up and tearing the peritoneum, injury to the subperitoneal connective tissue and other accidents of a like nature. (3) Laparotomy enables the surgeon to apply the ligature at a point of election, and affords him an opportunity of obtaining information as to the exact extent of disease in the main arterial trunk. (4) Laparotomy averts the dangers which were likely to follow ligature

of the internal iliac artery by the older operations, among which may be cited peritonitis resulting from tearing up the peritoneum posteriorly, cellulitis, purulent œdema, pelvic abscess, septicæmia and pyæmia. (5) Laparotomy occupies much less time for its performance in order to expose the internal iliac artery than was occupied to reach the vessel by the incision of Cooper or Abernethy. As gluteal aneurism, as a rule to which there is but one exception (which is doubtful), progresses steadily and rapidly to certain death from hæmorrhage, expectant treatment is out of the question.

Other methods have not proven eminently successful, the operation of Antyllus giving according to Holmes, four recoveries out of five cases; that of Anel, two recoveries out of four cases; perchloride of iron injection, four recoveries out of six cases; proximal compression on the aorta with direct compression, failure; ligature of the internal iliac by an incision parallel with Poupart's ligament and pushing back the peritoneum, six recoveries in eleven cases. It being recognized, however, that the Hunterian method of ligature of the main artery on the proximal side gives the best results, particularly where elastic compression is inapplicable as in the present instance, it remains to find a satisfactory way of applying it; from the recapitulation at the beginning of this abstract, laparotomy would seem to supply the desideratum. The author relates three cases, two of which occurred in his own practice: *A.* The first case occurred in a woman, æt. 60, who presented pulsatile tumours in both gluteal regions, the tumours dating back a year and a half, and pain in the region, three years back. The external parts being thoroughly purified, an incision in the median line from the umbilicus to the symphysis pubis was made, the pelvic viscera, which would have hindered the operation, drawn without into warm moist sponges and towels, the internal iliac arteries of both sides ligatured in succession with catgut, the viscera returned, the external opening closed and antiseptic dressing applied; the patient died with suppression of urine and slight parenchymatous nephritis on the third day thereafter. *B.* The second case occurred in the practice of Dr. W. L. Chew, of Birmingham, Ala., and was a gluteal aneurism of the right side of a male negro, æt. 46, the trouble dating back seven

months. By a curved lateral incision the abdomen was opened, owing to the violent efforts of the patient and the difficulty of manipulation, a few coils of intestine drawn out, strong silk ligature applied to the internal iliac, the parts cleansed, the incision closed and antiseptic dressing applied. Prompt adhesion occurred with rapid diminution of the tumour and cure. *C.* The third occurred in a female, æt. 18, and was associated with an aneurismal varix, the left side being affected; the trouble dating back many years. Under careful antiseptic precautions, the abdomen was opened, the incision finally extending from the symphysis to some distance above the umbilicus, the intestine drawn out sufficiently to permit the exposure of the vessel, a double twisted catgut ligature applied to the left internal iliac, the guts returned, the external incision closed and antiseptic dressing applied; the patient rallied quickly and the bowels moved normally on the fifth day; a slight acute albuminuria due to congestion of the kidney from the ligature of the main trunk of the internal iliac appeared on the following day, but soon disappeared. The aneurism together with the aneurismal varix was perfectly cured. These cases would seem to demonstrate satisfactorily the availability of this method of treatment, the only real obstacle to the successful issue of the operation being the occurrence of acute albuminuria, toward the prevention of which the study of surgeons should be directed.—*Med. News.* Nov. 20, 1886.

JAMES E. PILCHER (U. S. Army).

**II. B:asdor's Operation for Aneurisms of the Arch of the Aorta and of the Anonyma.** By Dr. J. ROSENSTIRN (San Francisco). This article contains details and statistics not only of the cases collected by Pilz and by Koch (von Langenbeck's *Archiv.*, Vols. IX and X) and notably by Wyeth (*Am. Jour. Med. Sci.*, 1881), but also of the scattered cases since published besides a new one of R.'s and one from Gerster (New York.)

The operation was doubtless first performed by Mott in 1820, though the first published case was that of Wardrop (London, 1825),

Only of late years has the operation been adopted in Germany.

R. has brought together a total of 99 cases. These he divides as follows :

## LIGATURE OF CAROTID AND RIGHT SUBCLAVIAN, 38 CASES

WITHOUT ANTISEPTICS.				WITH ANTISEPTICS.			
<i>Cured.</i>	<i>Improved.</i>	<i>Not Improved</i>	<i>Died from Operation.</i>	<i>Cured.</i>	<i>Improved.</i>	<i>Not Improved.</i>	<i>Died from Operation.</i>
2	—	1	3	14	5	5	8

## LIGATURE OF THE SAME VESSELS WITH AN INTERVAL BETWEEN, 10 CASES.

1	3	2	—	—	3	—	1
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## LIGATURE OF THE RIGHT COMMON CAROTID, 31 CASES.

2	2	5	16	3	—	—	3
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## LIGATURE OF THE RIGHT SUBCLAVIAN, 5 CASES.

1	1	1	1	1	—	—	—
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## LIGATURE OF THE LEFT COMMON CAROTID, 10 CASES.

—	2	1	1	2	2	—	2
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Under the second class Smith's case (cure) is not included. Besides the above there are four other cases.

*a.* Schede, 1884, ligature of left carotid and later of left subclavian, with improvement for a time.

*b.* Busch, 1880-1, ligature of left carotid and axillaris. Death three days p. o.

*c.* Wilhelm, 1826, left subclavian vein mistaken for the artery and tied. Death on seventh day.

*d.* Morris, 1882, internal jugular tied by mistake instead of the right carotid. Death on fourteenth day.

Co-ligature of left carotid and subclavian has never been performed, although Busch's case above approximated this.

R.'s patient was a Swedish woman, æt. 42. Present trouble began two and a half years before. Other forms of treatment unavailing. Pulsating. Tumour size of a hen's egg displacing trachea, causing great pain, loss of flesh, etc. He tied the right common carotid and

the subclavian November 26, 1883, in the German Hospital at S. F. The subclavian was readily secured. While freeing the carotid the anterior mediastinal space was punctured and some air drawn in when a compress closed the opening. Silk ligatures. Drainage tube and stitches removed at second change of dressing fourteen days later. The right radial pulse did not reappear until January 20, the temporal until March, 1884. The tumour slowly diminished, though it is still detectable. Pulsation at first diminished also, but of late has returned in full force. Patient last seen in April, 1886. She was again able to fill her place as housekeeper, and was free of her former suffering. Atrophy and wasting of the right arm, following the operation, were remedied by electricity and massage.

Despite the views of Holmes and Marsh (1885) and Küster, R. concludes from a study of the cases that co-ligation of both vessels is preferable to two separate operations. Ligation of the subclavian is certainly the more important part. In several of the cases subsequent autopsy showed the carotid to be still partially open. After briefly reviewing other methods of treatment and their results, he decides that ligation is far the most successful.—*Arch. f. klin. Chirg.* 1886. Bd. 34. Hft. 1.

## HEAD AND NECK.

I. The Formation of a New Nasal Skeleton from the Frontal Bone. By Prof. KÖNIG (Göttingen). In cases where the bony framework of the nose has been destroyed, all attempts heretofore at reconstructing a proper profile have failed.

In view of four fairly successful cases, K. here presents a method which he has devised. First, the soft parts (tip and alæ) are made mobile by a transverse cut through the most sunken (saddle) portion of the nose. If this lower part is then drawn down into its normal position, a broad gaping defect appears. This is first bridged over by cutting a  $\frac{3}{4}$  to  $1\frac{1}{2}$  ctm. wide oblong flap from the forehead perpendicularly upwards from the bridge of the nose. This flap includes skin, periosteum and cortical layer of frontal bone—the latter being cut around by a chisel. The whole is then loosened by following down